



Instructions to File a Claim for Disability Benefits

1. Complete all Sections of the Employee Statement.

2. Read the Tax Notice and complete it for voluntary Federal Income Tax withholding from disability benefit payments.

3. Ask your Doctor to complete an Attending Physician's Statement.

4. Submit these completed forms according to the directions you received from your Benefits Office.

5. If the Prudential Insurance Company of America ("Prudential") provides you with both short term and long term disability benefits, the claim for long term disability benefits will be considered as having been filed when the eligibility requirements for that coverage have been met. If you are unclear about whether or not Prudential provides you with both types of disability benefits, please consult your employer.

The Prudential Insurance Company of America Disability Management Services PO Box 13480, Philadelphia, PA 19101 Voice: 1-800-842-1718 Facsimile: 1-877-889-4885

WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

For your protection, certain state laws require the following to appear on this form:

CALIFORNIA RESIDENTS - For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NEW JERSEY RESIDENTS - Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW YORK RESIDENTS - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

PENNSYLVANIA RESIDENTS - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

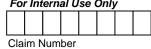




Group Disability Insurance Employee Statement

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1	Employer Name Control Number
Employer	Control Number
Information	Lacetian / Division
	Location / Division Branch Number
2	
	First Name MI Social Security Number
Employee Information	
orac.or.	Last Name Suffix
	Mailing Address - Line 1
	Mailing Address - Line 2 Birth date (MM/DD/Year)
	City State Zip Code Gender Marital Status
	Unmarried
	Married
	Primary Phone Number Work Phone Number O Divorced
	U O Widowed
	Email Address
	Date Last Worked (MM/DD/Year) Date First Absent Date First Treated for this Condition
	Date Expected to Return to Work
	EDUCATION:
	Highest Grade Completed: Number of Children Under 18: Age of Youngest Child:
3	Occupation
Job	
Information	What Job Category best describes your required job duties? (Please check appropriate box)
	C - S - S - S - S - S - S - S - S - S -
	Negligible Weight Up to 10 lbs. frequently 10 to 25 lbs. freq. 25 to 50 lbs. freq. More than 50 lbs. freq. (Please describe Up to 20 lbs. occasionally and / or and /
	Frequent Walk/Stand and / or
	Constant Push/Pull
4	Physician Name Primary Phone Number
Primary	
Care	Street Address Fax Number
Physician	
	City State Zip Code
	State Zip Code
	For Internal Use Only









Group Disability Insurance Employee Statement

	Employee Last Name					Social Securit	ty Number
						-	
5 Medical	All Other Physicians You H Physician		d for this (Condition	Specialty		Phone Number
Information							
							1
	What medical condition is preventing you from working?						
	How does this condition interfere with your ability to perform your job?						
	Have you been hospitalized for this condition?	O Yes C) No) In-Patie	ent O Out-Patie	¬	/ / / / / / / / / / / / / / / / / / /
	If you are / / / / / / / / / / / / / / / / / / /	ry Date /	Actu	al Deliver	/ Date /	To:/	/
	Name of Your Health Insur	ance Compan	ıy T			Telephone Numb	per
6 Other Income & Workers'	What other income are you Retirement Benefits, Worke Insurance, Salary Continua Please send copies of any	ers' Compensa ance, Group Li letters or notic	ation, Stat ife or Disa ces appro	e Disabilit bility Plan ving or de	y, Pension Disabi , Health or Welfar nying benefits.	lity or Retireme e Plan, Individu	nt, No-Fault Auto ual Disability Benefits.)
Comp.	Source	Applied For Yes No	Am	ount	Frequency	Date Benefit Begi	Date ins Benefit Ends
Information	Salary Continuance	0 0					
	State Disability Benefits	0 0					
	Workers' Compensation	0 0					
	Other:	0 0					
	Other:	0 0					
	Is this condition work related?	O Yes O	No If Ye	es, do you i	ntend to file a Worke	ers' Compensation	n claim? Yes O N
7 Fraud Notice	Any person who knowingly criminal and civil penalties. (Please see state specific for	This includes	Employer	and Atte	ing any false or m nding Physician po	isleading informortions of the cl	nation is subject to aim form.
	X Em	ployee Signatu	re			/	Date Signed









Group Disability Insurance Authorization

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- Pr	rudentiai 💯 Financiai	Authorization
1 Claimant	Social Security Number	Employee Phone Number
nformation	First Name	
	Last Name	Suffix
	Email Address	
	Employer Name	Control Number
2 Authorization o Release nformation	Authorization for Release of Information This Authorization is intended to co	
	I authorize any health plan, physician, health care profession other health care provider that has provided treatment, payment of the provided treatment, payment of the payment of the provided treatment of the provided treatme	nent or services to me or on my behalf ("My Providers") to

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided treatment, payment or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other health information concerning me to the Prudential Insurance Company of America (Prudential) and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

I authorize any insurance company, employer, the Social Security Administration, or other person or institutions to provide any information, data or records relating to my Social Security, Workers' Compensation, credit, financial, earnings, activities or employment history to Prudential.

Unless limits* are shown below, this form pertains to all of the records listed above.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct My Providers to release and disclose my entire medical record without restriction.

This information is to be disclosed under this Authorization so that Prudential may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) obtain reinsurance; 3) administer coverage; and 4) conduct other legally permissible activities that relate to any coverage I have or have applied for with Prudential.

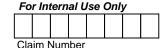
This authorization shall remain in force for 24 months following the date of my signature below, while the coverage is in force, except to the extent that state law imposes a shorter duration. A copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to Prudential at: PO Box 13480, Philadelphia, PA 19101. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that Prudential has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this authorization to release the entire medical record, Prudential may not be able to process my claim for benefits and may not be able to make any benefit payments. I understand that I have the right to receive a copy of this authorization.

*Limits, if any:	
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Claimant Signature	Date Signed

Notice to Montana residents: You or your authorized representative are entitled to receive a copy of this Authorization, and upon request, a record of any subsequent disclosures of personal or privileged information.









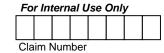


Group Disability Insurance Employee Tax Notice

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Employee Information First Name Last Name Last Name Employer Name Employer Name Control Number Employee Phone Number Suffix Employee Phone Number Suffix Employee Phone Number Employee Phone Number Suffix Employee Phone Number Employee Phone N
Information First Name Last Name Last Name Employer Name Employer Name Control Number Notice to all parties completing this form: It is fraudulent to fill out this form with information you know to be false or to omit important facts. Criminal and/or civil penalties can result from such acts. Benefits provided under your Group Disability Income Plan may be subject to federal, state and local taxation. Contact your employee benefits representative or disability plan trustee for details on your rights and obligations under the various tax codes. If you wish to have Federal Income Tax (FIT) withheld from any payments you may receive, indicate the amount to be withheld (\$20 weekly minimum for STD/\$88 monthly minumum for LTD) below and sign the authorization. Withholding requests may also be submitted on IRS Form W-4S. Withholding requests must be stated in whole dollar amounts. FIT will not be withheld if the disability benefit is not axable. I request voluntary Federal Income Tax withholding from each payment, as authorized under section
Last Name Suffix
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I request voluntary Federal Income Tax withholding from each payment, as authorized under section 3402(c) of the Internal Revenue Code, in the amount(s) of:
3402(c) of the Internal Revenue Code, in the amount(s) of:
For STD .00 weekly (\$20.00 minimum)
For LTD .00 monthly (\$88.00 minimum)
3
Employee V
Signature ^ L L L L L L
Employee Date Signed Signature











Group Disability Insurance Attending Physician's Statement



The Employee is responsible for the completion of this form without expense to Prudential Financial.

	esponsible for the completion of this form without expense to Fragential Financial.
1	Employer/Association Name Control Number
Employee	Employee First Name MI Social Security Number
Information	Employee First Name MI Social Security Number
	Employee Last Name Suffix
	Final super Address Line 4
	Employee Address - Line 1 Birth date (MM/DD/Year)
	Employee Address - Line 2 Gender
	→ Male → Female
	City State Zip Code
	Occupation
	I hereby authorize release of information requested on this form by the below named physician for the purpose of claim processing.
	x
	Employee Signature Date Signed
2	Clinical Diagnosis ICD-9 Code Pregnancy EDC
To Be	
Completed	Primary:
By	Secondary:
Attending	Secondary:
By Attending Physician	Secondary:
	Relevant test procedures performed (Please provide results)
	Relevant test procedures periornied (Flease provide results)
	Surgical procedure(s) performed (Please be specific): Date of Procedure: // / / / / / / / / / / / / / / / / /
	Current Medications:









Group Disability Insurance Attending Physician's Statement

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	Employee Last Name		Social Security Number
Attending Physician Information (Cont'd)	Was Claimant hospital confined?		If hospitalized, give dates: From:
	Other Treating Physicians or Consulta	nts	
	Physician Name	Specialty	Phone Number
	Do you feel the claimant is competent	to endorse checks and direct the use of	proceeds?
	Nature of Medical Impairment / Limitati	on (Please specify nature of correspond	ling loss of function)
	Date when significant loss of function of	occnired: \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	
	significant risk to self or others?)	trictions (i.e., What activities should the	cialmant not perform because of a
	Prognosis for Return to Function / Return	urn to Work:	
	Return to Work Plan (Please describ	pe): Target Date	e
	Return to Work Plan (Please describ	pe): Target Date	e
	Return to Work Plan (Please describ	pe): Target Date	e





Group Disability Insurance Attending Physician's Statement



	Employee Last Name Social Security Number
Attending Physician Information (Cont'd)	Describe Medical Obstacles to Return to Work:
	Are there any Non-Medical Factors which have a significant impact on Functional Abilities (i.e., interpersonal, financial, amily)?
	Work related illness or injury?
	Frequent Walk/Stand and / or Constant Push/Pull
Physician Information	Physician Name Primary Phone Number Office Address Fax Number
	Specialty State Zip Code Specialty
4 Fraud	Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
Notice	X Physician Signature

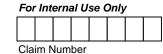




Group Disability Insurance Employer Statement

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1	Employer Name Control Number
Employer	
Information	Employer Phone Number Branch Number
	Email Address
Employee Information	First Name MI Social Security Number
	Last Name Suffix
	Address City City City City City City City City
	City State Zip Code
	Coverage in force Employee Phone Number Gender when absence began
	(check all that apply): STD O LTD Date employee became a covered O Male O Female
	STD Coverage Selected individual for the applicable Coverages: Date Hired (MM/DD/Year)
	O Core O Optional STD: / / / / / /
	LTD Coverage Selected LTD: / / Coverage Termination Date
	O Core O Optional / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / / _ / / / / / / / / /
·	Date Last Worked Date First Absent Date Work Was Resumed
	Normal Earnings Prior To This Absence Frequency of Normal Earnings
	(exclude bonus, overtime, etc.) Order Hourly Monthly Last Date Employer Paid Any Compensation
	\$ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
	Work Hours If not Mon thru Fri, Check Days Worked Employment Status
	Is the employee's work week Monday thru Friday?
	Number of hours worked Monday Thursday Sunday Hourly
	per normal work week: Tuesday Friday Other
	Does employee contribute toward the STD Premium? O Yes O No Does employee contribute toward the LTD Premium? O Yes O No
	If Yes: Pre Tax Post Tax If Post Tax: If Yes: Pre Tax Post Tax If Post Tax:
	% paid by employer % paid by employer
	% paid by employee % paid by employee









Group Disability Insurance Employer Statement

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	Employee Last Name				Social Security Nu	mber
						-
Employee Information (Continued)	Is employee covered under a	•□	roup Life Insurance	e Policy? O Ye	s O No	
Other Income, Deductions & Workers'	Please indicate any applicable should be withheld from the eligible to receive, benefits from the compensation, Social Secur Retirement or Pension Plan.	employee's be om any other : ity Disability or	nefits, if approved sources because of Retirement Bene	. Please also indic of this absence, su fits, Statutory Ben	cate if the employe ich as Salary Conti efits, No Fault Auto	e is receiving, or is nuance, Workers' Insurance,
Comp. Information	Source	Applied For Yes No	Amount	Frequency	Date Benefit Begins	Date Benefit Ends
	Salary Continuance					
	State Disability Benefits					
	Workers' Compensation					
	Other:					
	Other:					
	Has the employee indicated the absence is work related		es O No	Has a Workers' C claim been filed?	compensation	Yes O No
Job Information	Occupation What Job Category best descr	ibes the employ	ee's essential job du	ties? (Please check	DOT Job Co	ode:
	What Job Category best describes the employee's essential job duties? (Please check appropriate box) Sedentary Negligible Weight Mostly Sitting Negligible Weight Mostly Sitting Negligible Weight Constant Push/Pull Negligible Weight Wight Wight Wight Stand and / or Constant Push/Pull Negligible Weight Wight Wight Stand and / or Constant Push/Pull Negligible Weight Wight Wight Stand and / or Constant Push/Pull Negligible Weight Wight Wight Stand and / or Standard Push/Pull Negligible Weight Wight Stand Standard Push Standard Push Push Pull Negligible Weight Wight Wight Standard Push Standard Push Push Pull Negligible Weight Wight Standard Push Standard Push Push Pull Negligible Weight Wight Standard Push Standard Push Push Push Push Push Push Push Push					
	As the employer, would you lif Yes, please explain (reduce			-	•	
5 Fraud	Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. This includes the Employee and Attending Physician portions of the claim form.					
Notice	X				/_	
		Employer Sig	gnature		Date	e Signed







Prudential Financial Electronic Funds Transfer Authorization



Enrollment

To enroll in Prudential's Electronic Funds Transfer (EFT) payment service, please provide the following information. If you elect to have Prudential deposit the funds in your savings account, you must first check with your bank to obtain the correct bank transit routing number and account number for electronic deposit. Please note that a deposit slip does not contain acceptable banking information. If you have any questions, please call us toll free at (800) 842-1718.

2 Claimant Information	Employer Name Claimant First Name Last Name Social Security Number Primary Phone Number
3 Banking Information	Bank Name
	Bank Transit Routing Number Bank Account Number (Nine digit bank transit routing) Bank Account Number (Bank Account Number)
Payment Plan Agreement	I authorize the Prudential Insurance Company of America to make electronic fund deposits of my disability benefit payment to my account. I understand that any deposit made to an inactive account will be returned to Prudential and reissued as a manual check. In addition, if any overpayment of such disability benefits is credited to my account in error, I authorize Prudential to withdraw any payments necessary in order to assure the accuracy of my claim payments. I can cancel this authorization at any time by giving Prudential written notice. Any notice hereunder will not be deemed effective until Prudential has received my written notice.
	Account Owner Name
	Street Address
	City State Zip Code
	X













Instructions Only: It is not necessary to return this page with your EFT Authorization.

Instructions for completing Section 3, "Banking Information"

This will help you identify the necessary bank information to initiate electronic withdrawals. The nine-digit

routing number is how we recognize the bank you do business with.

Record all banking information on page 1 of the form in Section 3, "Banking Information". Please call your bank to confirm that the information you are supplying is correct.

Customer's Nan Street Address City, State, ZIP	ne		С	heck No. 1246
PAY TO THE ORDER OF				\$ Dollars
Bank Name Street Address City, State, ZIP				
A272078048A	006666D66666C	1246		

This is the bank transit routing umber.

It is always 9 digits and appears between the: ymbols.

Record this number in the boxes provided in Section 3, "nine-digit bank transit routing number.'

This is your bank account number. It varies in number of digits and may include dashes or spaces.

The < symbol indicates the end of the account number.

Record the account number in the boxes provided in section 3, "Bank Account Number" and include any dashes and spaces that are within the account number.

If there are any digits to the right of the < symbol (which do not represent the check sequence number), record them in the boxes provided

This is the check sequence number. It may be on either end of your check. Please do not include this on the authorization form.



